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No. 88-1503

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1989

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NANCY BETH CRUZAN, by her parents and co-guardians, LESTER L. and JOYCE CRUZAN,

*Petitioners,*

v.

ROBERT HARMON, Director of Missouri Department of Health, and DONALD LAMKINS, Administrator of the Missouri Rehabilitation Center at Mt. Vernon,

*Respondents,*

v.

THAD C. MCCANSE, Guardian *ad litem*,

*Respondent.*

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**On Writ of Certiorari to the Missouri Supreme Court**

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## BRIEF OF *AMICUS CURIAE* THE NATIONAL HOSPICE ORGANIZATION IN SUPPORT OF PETITIONERS

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## QUESTIONS PRESENTED

1. Whether the Constitution protects a dying person's decision to refuse unwanted medical intervention.

2. Whether a dying person's decision to refuse such intervention is vitiated by the person's subsequent incapacity.

3. Whether a State's asserted interest in forcing the continuation of life in all circumstances overcomes a dying person's right to refuse unwanted medical intervention.

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## BRIEF OF *AMICUS CURIAE* THE NATIONAL HOSPICE ORGANIZATION IN SUPPORT OF PETITIONERS

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### STATEMENT OF INTEREST OF AMICUS CURIAE

The National Hospice Organization ("NHO") is a non-profit, tax-exempt entity dedicated to improving the care of terminally ill Americans. The NHO was established eleven years ago and currently represents over 1,000 hospices across the country and an additional 2,000 individual members.

Since the first hospice in this country began caring for patients in 1974, more than 1,600 hospice programs have developed around the nation. A hospice program is a coordinated program of palliative and supportive services, including medical, psychological, social, and spiritual care for dying persons and their families. These services are provided by a medically directed interdisciplinary team of physicians, nurses, specialized therapists, social workers, and volunteers, and are provided both in the home and in inpatient settings.

The hospice philosophy recognizes dying as part of the normal process of living and focuses on enhancing the quality of remaining life. Hospice affirms life and seeks neither to hasten nor to postpone death. It also affirms the right of those who are dying to make as many choices as possible for themselves—both in living what is left of life and in dealing with fatal illness. An important component of hospice care, therefore, is enhancing the ability of patients to control their lives for as long as possible, even in the terminal phase of their illness.

Choosing hospice is a decision made by increasing numbers of dying patients. Other patients make different choices. In 1987, more than 188,000 terminally ill Americans were served by hospice programs. We estimate that more than one-third of Americans dying of cancer in 1987 and nearly forty percent of those who died of AIDS in that year were hospice patients. Moreover, hospices have cared for many patients who have chosen to forego artificial nourishment and who find in hospice maximal support for that choice and attentive care. Because we know from years of hospice experience that such a choice can bring comfort, not pain, to those who make it, and because it is a medically sound choice, we strongly endorse the right of the dying to make it.

It is this right of free choice that NHO seeks to preserve, together with the right to expect that a choice made by a competent individual will be honored, even if that



individual later becomes unable to express the choice in terms of a specific treatment decision. NHO is concerned that the Missouri Supreme Court's decision, if affirmed by this Court, would severely limit important choices made by dying patients, particularly those no longer capable of insisting that their choices be honored. For that reason, we file this brief amicus curiae.[1]

## SUMMARY OF ARGUMENT

> As the Bible teaches, the road which opens with birth leads to the grave. Birth and death are the most singular events we experience and, therefore, the contemplation of death as of birth should be a thing of beauty and not of ignobility.[2]

Such was the testimony of Jacob Javits at a Congressional hearing, shortly before his death. Not everyone has spoken on this subject as eloquently, but many have come to appreciate the importance of communicating their thoughts on such matters. Accordingly, most States—including Missouri—have enacted laws validating advance directives for health care (such as living wills and durable powers of attorney).[3]

Maintaining control over the manner of one's dying is a fundamental aspect of personal liberty. For dying is by definition a *personal* matter; it may be painful or peaceful, humiliating or liberating, depending on how each

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[1] This brief is filed with the consent of the parties. Copies of the consent letters are on file with the Clerk.

[2] *Dying With Dignity: Difficult Times, Difficult Choices:* Hearing Before the House Select Committee on Aging, 99th Cong., 1st Sess. (Comm. print 1985) at 5-6 (testimony of former Senator Jacob Javits). When he testified, Senator Javits was terminally ill—and totally paralyzed from the neck down—a condition which, as he observed, "concentrates the mind on this subject." *Id.*

[3] *See, e.g., A Matter of Choice: Planning Ahead for Health Care Decisions*, Senate Special Comm. on Aging, S. Rep. No. 211, 99th Cong., 2d Sess. (1986).

individual experiences the process. Indeed, controlling the process is often the last possible expression of one's individuality; and maintaining control over that individuality and over what is done to them during a terminal illness is for many patients a crucial part of hospice care. When patients lose that control, they lose their dignity, their bodily integrity, and their sense of self.[4] Deciding to forego aggressive treatment when there is no hope of recovery is for some an affirmation of self and of control. It is for them an acceptance of the inevitable.

For nearly fifteen years, state and federal courts across the country consistently have concluded that the Constitution protects such choices by the dying and guards them from the State's insistence that they accept life-sustaining treatments they do not want. The first such case, that of Karen Ann Quinlan,[5] has been followed by many others, all endorsing this basic principle.[6] This Court's own prior decisions likewise confirm the right of persons to be free from State intrusion upon their bodies and their beliefs, particularly when fundamental, personal decisions are at issue. The Court should confirm in this case that the choice of the dying to refuse unwanted treatment is such a fundamental, personal decision and that it is constitutionally protected.

Contrary to the implications of the Missouri Supreme Court's decision, this fundamental, personal choice should not be ignored—nor can it be considered vitiated—simply because a dying person has become incapacitated. Even though incapacitated, dying persons are still persons, and

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[4] *See, e.g.*, Buschman, "Psychosocial Issues in the Care of the Terminally Ill" in J. Zimmerman, *Hospice: Complete Care for the Terminally Ill*, (2d ed. 1986) at 77.

[5] *In re Quinlan*, 335 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976), *overruled in part*, *In re Conroy*, 486 A.2d 1209 (N.J. 1985).

[6] *See, e.g., Brophy v. New England Sinai Hosp.*, 497 N.E.2d 626 (Mass. 1986) and cases cited therein.



they still possess their basic constitutional rights. When their choice regarding the acceptance or nonacceptance of prolonged life-sustaining treatment is known, it should be honored.

Describing *Cruzan* as a case in which a "third party seeks to cause the death of an incompetent," [7] or in which the issue is whether guardians may "choose the death of their ward,"[8] or in which "we are asked to allow the medical profession to make Nancy die," [9] inflames but does not inform. Moreover, it distorts—if it does not ignore altogether—the true human interests at stake. Neither Nancy Cruzan nor her parents chose the accident that left her incapable of rudimentary bodily functions [10] and forever incapable of cognitive life,[11] just as no one ever chooses terminal illness. It is not that her parents wish Nancy dead; it is that they do not want her death to be held in abeyance in a manner they know (and the trial court found) is inconsistent with Nancy's clearly expressed wishes.[12]

The Missouri Supreme Court's claim that the State has an overriding interest in insisting that dying people accept unwanted, unremitting life-sustaining treatment—even where there is no hope of recovery—should not be

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[7] Appendix to Petition for Writ of Certiorari ("Pet. App.") at A41.

[8] *Id.* at A44.

[9] *Id.* at A9.

[10] She has "no cognitive or reflective ability to swallow food or water to maintain her daily essential needs." *Id.* at A8.

[11] She is "oblivious to her environment except for reflex responses to sound and perhaps painful stimuli" due to "cerebral cortical atrophy [which] is irreversible, permanent, progressive and ongoing." *Id.* at A7.

[12] The trial court found as fact that Nancy "would not wish to continue with nourishment and hydration" under the circumstances here presented. *Id.* at A8.

accepted by this Court. The State has a valid interest in protecting life, but that interest does not warrant unwanted intrusion upon the dying.

Furthermore, neither the State legislature nor the Missouri Supreme Court has explained why the State's concern with protecting life requires forcing substances into dying bodies through feeding tubes, while not requiring forcing oxygen into those bodies through ventilators. Yet the State permits the latter to be refused, but not the former. Because there is no justification for this dissimilar treatment (*i.e.*, between patients whose nourishment is provided mechanically and those whose respiration or kidney function are provided mechanically), the State's action in this case not only subverts fundamental constitutional liberties, it also violates the Equal Protection Clause of the Fourteenth Amendment.

## ARGUMENT

### I. DYING INDIVIDUALS HAVE A FUNDAMENTAL RIGHT TO MAKE CHOICES ABOUT THEIR MEDICAL CARE

The right of individuals to decide what medical procedures (if any) may be performed on them was first enunciated in 1914.[13] This fundamental right is implemented through the process of informed consent, which provides an opportunity for an informed patient to decide whether or not to accept the proffered therapy,[14] based upon personal values and goals, religious and moral beliefs, and an individualized weighing of burdens and benefits. Accordingly, the right to consent necessarily includes the corollary right to refuse medical treatment;[15] and the right to refuse is not limited to any particular kind of treatment or circumstances.

> [I]t is now a well-established rule of general law . . . that it is the patient, not the physician, who ultimately decides if treatment—any treatment—is to be given at all . . . . The rule has never been qualified in its application by either the nature or purpose of the treatment, or the gravity of the consequences of acceding to or foregoing it.[16]

Moreover, consent is a continuing process and the patient always has the right to withdraw consent previously given.[17]

In 1976, these well accepted principles became the cornerstone of the *Quinlan* decision, in which the Supreme Court of New Jersey ruled that the right of privacy includes the right to refuse life-sustaining medical treatment.[18] *Quinlan* reflected in part this Court's affirmation that the United States Constitution protects personal medical decisions such as the use of contraception.[19] This Court has since ruled that prisoners and mental

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[13] *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his body and cannot be subjected to medical treatment without his consent").

[14] *See generally Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); *Cobbs v. Grant*, 502 P.2d 1 (Cal. 1972). *See also Natanson v. Kline*, 350 P.2d 1093 (Kan.), *clarified*, 354 P.2d 670 (Kan. 1960).

[15] *See, e.g., Rasmussen v. Fleming*, 741 P.2d 674, 683 (Ariz. 1987) (en banc).

[16] *Tune v. Walter Reed Army Medical Hosp.*, 602 F. Supp. 1452, 1455 (D.D.C. 1985) (citations omitted).

[17] *Brophy*, 497 N.E.2d at 638 and cases cited therein. *See also Tune*, 602 F. Supp. at 1456 ("competent adult patients . . . with terminal illnesses and in the circumstances presented here have a right to determine for themselves whether to allow their lives to be prolonged by artificial means, *including the right to demand the cessation of life support once begun*") (emphasis added).

[18] *In re Quinlan*, 355 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976), *overruled in part, In re Conroy*, 486 A.2d 1209 (N.J. 1985).

[19] *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Eisenstadt v. Baird*, 405 U.S. 438 (1972).

patients have constitutionally protected liberty interests that are implicated by the administration of drugs against their will;[20] and that even a small incision to remove a bullet from a criminal suspect "implicates expectations of privacy and security of such magnitude that the intrusion may be 'unreasonable' even if likely to produce evidence of a crime."[21]

The Court now addresses, for the first time, the extent to which the Constitution affords dying individuals a right against unwanted invasion of bodily integrity. We believe that interest is at least as strong as the other circumstances in which the Court has already confirmed a right to be free from State intrusion upon fundamental human decisions. Surely the right to control the manner of one's dying deserves as much protection under our Constitution as the right to control conception; and if brief insertion of a tube to remove stomach contents offends,[22] so much more does the permanent insertion of a tube to force substances into the stomach of an unwilling, dying individual.

Courts throughout the States uniformly have invoked federal constitutional rights in affirming a patient's right to refuse life-prolonging treatment. Until *Cruzan v. Harmon*, courts consistently—and correctly—have held that to deny patients freedom of choice concerning health care would be to infringe their constitutional rights:

> The constitutional right to privacy, as we conceive it, is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life so perceived is lessened not by a decision to refuse treatment, but

[20] *Mills v. Rogers*, 457 U.S. 291 (1982); *Addington v. Texas*, 441 U.S. 418 (1979).

[21] *Winston v. Lee*, 470 U.S. 753, 754 (1985).

[22] *Rochin v. California*, 342 U.S. 165 (1952).



> by the failure to allow a competent human being the right of choice.[23]

The *Cruzan* court overlooked this crucial fact, *i.e.*, that the right to privacy embodies more than mere control over painful bodily intrusions. It extends as well to one's sense of self and one's emotional well-being. These are primary concerns of many who are dying—persons who wish to be remembered other than as a senseless organism with tubes delivering and removing various substances through bodily orifices.

In his well-known description of the right to privacy, Justice Brandeis reminds us that the makers of our Constitution "recognized the significance of man's spiritual nature, of his feelings and of his intellect. They knew that only a part of the pain, pleasure and satisfactions of life are to be found in material things."[24] As former Solicitor General Charles Fried has written:

> What a person is, what he wants, the determination of his life plan, of his concept of the good, are the most intimate expressions of self-determination, and by asserting a person's responsibility for the results of this self-determination we give substance to the concept of liberty.[25]

A patient's privacy may be invaded, and his liberty violated, even without the administration of highly intrusive procedures and without any experience of physical pain. It is enough that something is done that the patient

[23] *Tune v. Walter Reed Army Medical Hosp.*, 602 F. Supp. at 1456, quoting *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417, 425-426 (Mass. 1977); *accord Brophy*, 497 N.E.2d at 633; *Rasmussen*, 741 P.2d at 681-682; *In re Gardner*, 534 A.2d 947, 955 (Me. 1987).

[24] *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J. dissenting).

[25] C. Fried, *Right and Wrong*, at 146-147 (1978), *quoted with approval in Thornburgh v. American Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 777 n.5 (1986) (Stevens, J. concurring).

does not want. It is enough that the intimate aspects of one's being are exposed to others through unwanted procedures. Often, what dying patients fear most is continued existence under conditions that are humiliating even to contemplate; and it is the indignity and loss of control, rather than physical pain, that the patient hopes most fervently to avoid. William Bartling, for example, described the "degrading and dehumanizing" impact of receiving unwanted life support and gave the following reasons for petitioning a California court for the right to have a respirator removed:

> I am totally unable to care for myself and believe that I am dependent on a mechanical ventilator to support and sustain my respiration and life. I continuously suffer agonizing discomfort, pain and the humiliating indignity of having to have my every bodily need and function tended to by others. I do not wish to continue to live under these conditions.[26]

Such concerns are equally valid when expressed prospectively, in anticipation of the degradation. In 1987, the Supreme Court of Maine authorized removal of nasogastric feeding tubes from a patient who previously had made clear his intent never to be dependent upon such equipment. In its opinion, the Court observed:

> It is apparent from the testimony that what was on [the patient's] mind was not only the invasiveness of life-sustaining systems, such as the NG tube, upon the integrity of his body. It was also the utter helplessness of the permanently comatose person, the wasting of a once strong body, and the submission of the most private bodily functions to the attention of others. In the face of those understandable concerns, "[t]he law recognizes the individual's right to preserve his humanity, even if to preserve his humanity means to allow the natural processes of a

[26] *Bartling v. Glendale Adventist Medical Ctr.*, 209 Cal. Rptr. 220, 222 (Cal. Ct. App. 1984).



> disease or affliction to bring about a death with dignity." [27]

Similarly, the Supreme Court of Minnesota assumed that a patient who had not provided advance directives on this point, nevertheless "may well have wished to avoid, as one writer vividly put it, 'The ultimate horror [not of] death but the possibility of being maintained in limbo, in a sterile room, by machines controlled by strangers.' " [28]

As hospice providers well know, the sentiments described above are common in dying people for whom maintaining control over treatment is essential to human dignity and emotional health. Indeed, one of the most frustrating and frightening aspects of illness and hospitalization is the sense of losing control and thereby losing individuality.[29]

> Serious illnesses of all kinds bring with them difficult psychosocial problems. Feelings of fear, depression, loneliness, and loss of control are almost universal among the sick . . . . The fact of imminent death introduces the whole panorama of problems related to death, separation, and loss. Superimposed now on the fear of pain and discomfort arising from illness are fears about dying and death. For the patient this includes fear of loss of dignity, autonomy, identity, and personhood.[30]

[27] *In re Gardner*, 534 A.2d at 953, quoting *Brophy*, 497 N.E.2d at 635.

[28] *In re Torres*, 357 N.W.2d 332, 340 (Minn. 1984) (citation omitted).

[29] *A Matter Of Choice*, *supra* n.3, at 4-5. *See also* Rodin, "Aging and Health: Effects on the Sense of Control," 233 *Science* 1271 (Sept. 19, 1986); Viner, "Life at the Other End of the Endotracheal Tube: A Physician's View of Critical Illness," 2 *Prog. Crit. Care Med.* 3 (1985), *reprinted in Dying With Dignity: Difficult Times, Difficult Choices:* Hearing Before the House Select Comm. on Aging, 99th Cong., 1st Sess., at 79 (Comm. print 1985).

[30] J. Zimmerman, *Hospice: Complete Care for the Terminally Ill* at 3 (2d ed. 1986).

As a consequence, one of the human problems hospice nurses must learn to identify and treat has been termed "annihilation anxiety," in which:

> The staff and family become "they" or "those people", just as the patient fears becoming only a number or a thing. Fear of losing sanity means fear of losing whatever makes sense and becoming nothing at all.[31]

Thus, dying patients need more than freedom from painful procedures; they need to maintain control and to chart their own course. This Court recognized the importance of such self-determination and personal dignity when it ruled that compulsory surgery performed under anesthesia violated the Fourth Amendment—not because of any physical pain, but because surgery under anesthesia "involves a virtually total divestment of [one's] ordinary control" over the procedures performed.[32] Yet, out of a short-sightedness and an insensitivity that bordered on the inhumane, the Missouri Supreme Court overlooked (or ignored) all these critical values and interests that lie at the core of personhood. Without analysis, it simply declared that the State's forced intrusion upon the dying was no burden to them and was therefore justified.[33] As hospice providers and those they serve well know, the court could not have been more wrong. Being stripped of dignity and autonomy as death approaches is the ultimate burden for the dying. Our Constitution should be held to prohibit it.

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[31] Buschman, *supra* n.4 at 77, 82, quoting Weisman, "Psychosocial Considerations in Terminal Care," in Schoeberg, Carr, Peretz and Kutscher (eds.), *Psychosocial Aspects of Terminal Care* 162 (1972).

[32] *Winston v. Lee*, 470 U.S. at 765.

[33] According to the court, "the burdens" associated with unwanted treatment are "not excessive" or "substantial to the patient and whatever "constitutional right" the dying may have "to refuse [such] treatment" is always "outweigh[ed]" by "[t]he State's interest in the preservation of life." Pet. App. at A38, A43.



## II. THE RIGHTS OF DYING INDIVIDUALS ARE NOT EXTINGUISHED BY THEIR INCAPACITY

That an individual's constitutional rights are not terminated by illness or incapacity should go without saying. As virtually every court addressing the question has ruled: "the right of terminally ill patients should not be lost when they suffer irreversible brain damage, become comatose, and are no longer able to personally express their wishes . . . ." [34] Rather, the right to refuse treatment "must extend to the case of an incompetent, as well as a competent, patient because the value of human dignity extends to both." [35] Indeed, equal protection requires that it be so.

> What possible societal policy objective is vindicated or furthered by treating the two groups of terminally ill *differently*? What is gained by granting such a fundamental right only to those who, though terminally ill, have not suffered brain damage and coma in the last stages of the dying process? The very notion raises the spectre of constitutional infirmity. . . .[36]

To deny to the incapacitated the right to have a prior treatment choice implemented would discriminate against the disabled by depriving them of a constitutional right solely because their capacity to assert that right is impaired.

The only difference between competent and incompetent patients in this regard is *the means* by which their right to refuse treatment is implemented.[37] Many states au-

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[34] *John F. Kennedy Memorial Hosp. v. Bludworth*, 452 So.2d 921, 924 (Fla. 1984).

[35] *Saikewicz*, 370 N.E.2d at 427.

[36] *Id.*, quoting *Eichner v. Dillon*, 426 N.Y.S.2d 517 (N.Y. App. Div. 1980), *mod. & consolidated sub nom. In re Storar*, 420 N.E.2d 64 (N.Y.), *cert. denied*, 454 U.S. 858 (1981), (emphasis in original).

[37] *John F. Kennedy Memorial Hosp. v. Bludworth*, 452 So.2d at 924-925; *Saikewicz*, 370 N.E.2d at 423.

thorize advance directives, such as "living wills" and durable powers of attorney, through which individuals provide instructions about their health care to be implemented in case of subsequent incapacity.[38] Yet in this case the Missouri Supreme Court strongly suggested that even a properly executed living will should not be honored because a person could *never* know in advance the precise medical facts necessary for making an informed choice at some future time.[39]

Further, both the Missouri Supreme Court and the State's Attorney General take the extraordinary position that certain kinds of treatment—such as forced nutrition and hydration—are *always* beyond the control of the individual, either while competent or through an advance directive such as a living will.[40] Such reasoning renders living wills nugatory and takes from the dying the right of choice at the moment when that right is most important to them. This Court should not accept that view.

The right to refuse treatment is meaningless unless it survives incapacity. Any other view would eviscerate the right and lead to intolerable results.

> It may be that a patient will make an informed decision against undergoing a particular procedure yet, once the person's condition deteriorates to be life-threatening, the physician may perform the procedure against the patient's will on the grounds that the situation was an emergency and informed consent was therefore not required.[41]

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[38] *See generally A Matter of Choice, supra* n.3.

[39] Pet. App. at A21 ("It is definitionally impossible for a person to make an informed decision—either to consent or to refuse—under hypothetical circumstances"). *See also,* Pet. App. at A37.

[40] In so ruling, the State admittedly rejects the rulings of virtually every state and federal court that previously addressed this issue. Pet. App. at A10, n.4 and A29-30.

[41] Andrews, "Informed Consent Statutes and the Decisionmaking Process," 5(2) *J. Legal Med.* 163, 208 (1984). *See also, Leach v.*



Accordingly, if a patient rejects life-sustaining treatment with a clear understanding of the effects of such refusal—which the trial court found to be the case with Nancy Cruzan—"the materialization of such effects should not be used to invalidate the decision made while competent." [42] This Court should so hold in this case.

## III. THE STATE HAS NO INTEREST SUFFICIENT TO OVERRIDE THE TREATMENT CHOICES OF DYING INDIVIDUALS

Missouri's living will law affirms that every individual "has the primary right to request or refuse medical treatment subject [only] to the state's interest in protecting innocent third parties, preventing homicide and suicide and preserving good ethical standards of the medical profession." [43] The Missouri Supreme Court acknowledged that none of those three enumerated State interests is implicated in this case.[44] But the court nevertheless perceived a fourth "unqualified" State interest —preservation of life no matter the circumstances of that life—and proclaimed this interest paramount even though *the legislature* did not include that interest in its list of considerations that would limit an individual's right to refuse medical treatment. It strains credulity that the legislature would fail even to mention an interest it considered to be of such overriding importance.

In any event, the State's supposed interest in the protection of life cannot overcome a dying person's right to bodily integrity and personal dignity: "[t]he notion that the individual exists for the good of the state is, of

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*Shapiro,* 469 N.E.2d 1047, 1053 (Ohio Ct. App. 1984) ("a physician could circumvent the express wishes of a terminal patient by waiting to act until the patient was comatose and critical").

[42] Andrews, *supra* n.41 at 208.

[43] Mo. Rev. Stat. § 459.055(1) (1985).

[44] Pet. App. at A25.

course, quite antithetical to our fundamental thesis that the role of the state is to ensure a maximum of individual freedom of choice and conduct." [45] An unexplained, undifferentiated State insistence on prolonging life in every case—no matter the circumstances, no matter the deprivation of personal freedom to the dying—should not be found sufficient to undo basic individual rights.

Nor may the State limit the exercise of such rights by invoking distinctions for which a rational basis is neither proposed nor supportable. Given that one has a fundamental right to accept or decline medical treatment, the State may not deny to patients receiving artificial nourishment the rights afforded to patients receiving artificial respiration, without demonstrating that the two groups of patients differ in a legally relevant way.[46] No such showing has been made nor could be made.

Indeed, the organized medical community has concluded that artificial nourishment and hydration constitute medical treatment that is no different medically or morally from other life-sustaining procedures. The AMA Judicial Council has in fact issued the following opinion:

> Even if death is not imminent but a patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for the care of the patient, it is not unethical to discontinue all means of life-prolonging medical treatment.
>
> *Life-prolonging medical treatment includes* medication and *artificially or technologically supplied respiration, nutrition or hydration.* In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens. At all times, the dignity of the patient should be maintained.[47]

[45] *In re Osborne*, 294 A.2d 372, 375 n.5 (D.C. 1972).

[46] *Eisenstadt*, 405 U.S. at 447-448.



With the exception of the *Cruzan* court, the state and federal courts that have addressed the issue have uniformly held that there is no legal basis for distinguishing the artificial provision of nutrition and hydration through a gastrostomy tube from any other procedure which supplants a necessary bodily function.[48] Moreover, the notion that artificial nutrition and hydration differ from artificial respiration or kidney dialysis is insupportable in view of the fact that a patient dies just as surely from the removal of the latter as the former.

The State of Missouri, like all States, does indeed have significant interests—and responsibilities—in protecting life. But it also has the obligation to distinguish among the persons it seeks to protect, and to recognize that some of those persons do not need, do not want, and are entitled to reject the State's "protection." The National Hospice Organization knows from years of experience that many of the dying are included in that group of people. We submit that their choice to reject State "protection" is a basic right that should be honored by the Court in this case.

[47] Council on Ethical & Judicial Affairs of the American Medical Association, *Current Opinions* (1986) Opinion 2.18 (emphasis added). *See also "The Appleton Consensus: Suggested International Guidelines for Decisions to Forego Medical Treatment"* (1988), reprinted in 151(11) *J. of Danish Med. Assoc.* 700 (1989).

[48] *See In re Gardner*, 534 A.2d at 954 and cases cited therein. *See also In re Prange*, 527 N.E.2d 303 (Ill.), *cert. denied*, 109 S. Ct. 229 (1988).

## CONCLUSION

This Court should reverse the decision of the Supreme Court of Missouri, should recognize the right of the dying to refuse unwanted treatment, should recognize further that that right is not extinguished by incapacity, and should recognize finally that the State has no interest sufficient to override that right.

Respectfully submitted,

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